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Commentary

Violence Against Women and Reproductive Health: Toward Defining a Role for Reproductive Health Care Services

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Since a large proportion of U.S. women receive reproductive health care services each year, reproductive health care settings offer an important opportunity to reach women who may be at risk of or experiencing intimate partner violence (IPV). Although screening women for IPV in clinical health care settings has been endorsed by national professional associations and organizations, scientific evidence suggests that opportunities for screening in reproductive health care settings are often missed. This commentary outlines what is known about screening and intervention for IPV in clinical health care settings, and points out areas that need greater attention. The ultimate goal of these recommendations is to increase the involvement of reproductive health care services in sensitive, appropriate, and effective care for women who may be at risk of or affected by IPV.

KEY WORDS: Intimate partner violence; reproductive health; health care services; prevention; violence against women.

INTRODUCTION

Screening women for violence in clinical health care settings has been endorsed by national professional associations and organizations that focus on reproductive health (1, 2), maternal–child health (3–5), and women's health (6). However, available data indicate that most women who receive reproductive health care services are not screened for violence in routine reproductive health care visits (7–9). Although approximately 72% of U.S. women aged 15–44 years receive at least one reproductive health care service annually (10), evidence suggests that these potential opportunities to identify, refer, and consequently help abused women obtain intervention services are often missed (7–9).

National data for 1992–1996 indicate that risk of violence by a current or former intimate partner[5] peaks among women of reproductive age and is highest among women aged 20–24 years (11). Additionally, a recent review of the prevalence of intimate partner violence (IPV) during pregnancy reports that between 4% and 8% of pregnant women experience violence during their pregnancy, suggesting that violence is more common among pregnant women than health conditions such as diabetes or preeclamsia which are routinely screened for during pregnancy (12). Moreover, women who have experienced IPV have reported higher prevalence of risk factors and behaviors that can result in poor reproductive health outcomes, including young age at sexual initiation,

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[5]Since the majority of physical violence against women is perpetrated by a current or former spouse, partner, or boyfriend, this paper focuses on intimate partner violence (IPV).

substance abuse, multiple sex partners, and infrequent condom use (13–15). Findings from the Commonwealth Fund's 1993 National Survey of Women's Health indicate that women who had experienced IPV were more likely to report having had gynecologic problems, a sexually transmitted disease, or a urinary tract infection (16). Other studies have found associations between IPV and pelvic pain (17), chronic headache (18), or functional bowel disorder (19). Women whose pregnancies were unintended (20, 21) and those whose pregnancies resulted in induced abortion (22, 23) have also been found to report higher rates of IPV than in the general population.

Each encounter within a reproductive health care setting offers a potential opportunity to reach a woman who could be at risk of or affected by IPV. The ultimate goals of screening and intervention through reproductive health services should be to improve the health and safety of women and their children and to assist in reducing and preventing violence. However, our understanding of the most effective role for reproductive health care services in attaining these goals is still limited. Although a considerable amount of research has been devoted to determining why clinicians do not screen for violence and to identifying measures that can increase screening rates in health care settings, the impact of screening on women's lives has been generally unexamined. Little progress has been made toward defining specific and measurable outcomes of clinical interventions based on meeting the needs of women who have experienced or are at risk of IPV. As long as the desired outcomes of clinical interventions remain uncertain and undocumented, the potential role of reproductive health care services in identifying and treating or referring women who experience IPV will be difficult to define. The purpose of this paper is to outline what we know and what we need to know from the perspectives of health care providers, women who use reproductive health care services, and health care institutions, in order to increase the involvement of reproductive health care services in sensitive, appropriate, and effective care for women who may be at risk of or affected by IPV.

THE ROLE OF REPRODUCTIVE HEALTH CARE SERVICES

Health Care Providers

Studies that have collected data from reproductive health care providers indicate that less than half of providers routinely screen for IPV. A physician survey of California primary care physicians found that obstetricians/gynecologists were more likely than internal medicine physicians to screen new patients for IPV (17% vs. 6%), but they were no more likely than other primary care physicians to screen at routine checkups (10%) (7). A study of fellows of the American College of Obstetricians and Gynecologists reported by Horan *et al.* found that a higher proportion (39%), but still less than half, of providers reported conducting routine screening at first prenatal visit (8). Data from a study by McGrath and colleagues indicate that 18% of pregnant women examined at an urgent care triage unit reported having been asked about abuse by a physician (9). Variations in these data may be due to different methodologies used and different populations sampled.

Documented low levels of screening for IPV in primary care settings have led researchers and clinicians to identify barriers to increasing routine screening and, to a lesser extent, to design interventions to overcome these barriers. A recent review of 24 studies that examined health care provider behaviors related to screening for IPV in a variety of primary care settings (24) found that the most commonly identified barriers were lack of time for screening, lack of provider education or training, lack of effective interventions, and fear of offending patients. Other barriers cited by providers included frustration over patients failure to disclose IPV, and concerns about patient noncompliance with recommendations. Twelve studies reviewed by Waalen *et al.* (24) and three additional analyses (25–27) have evaluated interventions to overcome barriers and to change provider behaviors related to screening for abuse and assisting abused women. Most found that didactic educational programs alone did not change screening behaviors over the long term. In contrast, interventions that combined education with institutional supports such as having a designated staff person serving as a "violence specialist" and efforts to provide an emotionally supportive environment for clinicians in staff meetings and training sessions appeared to have greater chance of changing provider behavior (24). Most of these studies used increased rates of identification of IPV as the primary outcome measure of success (28–36).

Despite its common use as an indicator of success, however, increased patient disclosure to clinicians does not adequately measure screening effectiveness because it does not take into account what happens to women after screening occurs. In cases

where women respond to screening with disclosure of abuse, we need to know whether health care providers and settings are equipped with responses that can assist women either to decrease the risk of future IPV or to increase well-being in some measurable ways. For women who do not disclose violence directly to a provider when asked, understanding the possible effects of screening is much more complicated, but nevertheless important.

In a recent qualitative study exploring the experiences and screening practices of physicians with expertise in domestic violence, Gerbert and colleagues found that the rarity of direct patient disclosure resulted in "burnout" among physicians who conducted routine screening (37). In Gerbert *et al.*'s study, the lack of direct patient disclosure resulted in providers' perceptions that their efforts were not effective. In large part, these perceptions are due to the general lack of data on the actual effects of screening on the women who are screened, regardless of their disclosure to a health care provider. Gerbert *et al.*'s study and related commentary by Warshaw (38) suggest a need to redefine the goal of screening for violence so that compassionate screening is viewed as a successful outcome, through the creation of an atmosphere of trust and assisting patients regardless of the abused patient's direct disclosure to the clinician. Redefining the goals of screening indeed may be an important key to helping health care providers feel more positive about it. Although these attempts to identify appropriate outcome measures are important, they offer little insight into the contribution of screening toward the end goal of improving women's situations. Clinicians have consistently cited "lack of effective interventions" as a reason for not screening routinely, and until they have measurable goals based on successful intervention models to guide their work, this barrier is likely to persist.

Women Who Seek Reproductive Health Services

An essential key to the identification of appropriate goals and outcome measures for clinical screening and intervention must be the perspectives and experiences of women themselves. To date, research has focused primarily on barriers to disclosure from the perspectives of women who have experienced violence. In six studies that have asked abused women about their experiences with health care providers (13, 39–44), most women interviewed were in favor of clinical screening for violence. Despite this, respondents have described clinicians as uninterested, uncaring, and uncomfortable in addressing the issue of violence (43). Shame was cited by abused women as a principal reason for nondisclosure (39, 40, 42–44). Additional barriers reported by women included feelings that they would be blamed for the abuse and lack of time to discuss the issue with a health care provider (43). In a survey by The Commonwealth Fund, women experiencing spousal abuse were significantly more likely than those who were not to feel that physicians were difficult to talk with, did not listen well, and in some cases suggested that their problem was "in their head" (13). Despite these general findings on barriers to disclosure, we know little about why or when women choose to disclose past or current intimate partner violence to a health care provider. Is disclosure more likely to occur during acute phases of violence? What individual patient characteristics are associated with likelihood of disclosure to a clinician? What characteristics of clinicians or clinical settings most foster women's feelings of trust and comfort?

Furthermore, a critical next step for research is to examine the effectiveness of routine screening for women who seek reproductive health care services. Few evaluations of clinical interventions to address violence have gathered data from women. In a case–control study by Parker *et al.* (45), pregnant women in abusive relationships who received counseling sessions designed to reduce further abuse were compared with those who were only given resource cards. At 6 and 12 months postpartum, the use of community resources was found to be associated with the severity of abuse in the relationship and not to the intervention provided. Although Parker *et al.*'s study shed little light on the effectiveness of the clinical intervention, it contained the critically needed research component of follow-up to determine what happens to women after they leave the clinical setting where screening has occurred. Have these efforts improved the safety and well-being of women and their children, and if so, what specific outcome measures can be used to document such improvements? Appropriate indicators for short-term or intermediate effects of clinical intervention may not be specifically related to reducing violence, but to improvements such as successful referral to psychological counseling, decreased depression, or linkages to support networks. Conversely, we must be concerned about clinical efforts increasing some women's risk of further violence. Women's concerns about retaliation by a violent partner, confidentiality, mandatory reporting,

and insurance denial must be considered as we identify and evaluate outcomes.

Health Care Institutions and Organizations

There is growing recognition that the health care system must change in order to improve the role of health care services in addressing violence against women. Changes in clinical practice must be supported by institutional environments and professional organizations that provide clinicians with appropriate knowledge, skills, and institutional backing necessary to incorporate the issue of violence against women into their practice. Managed care organizations have been in the forefront of developing a health care systems approach to the issue of violence against women. In an assessment of domestic violence initiatives that have been implemented in managed care organizations, the American Association of Health Plans summarized some of the lessons learned from four programs in managed care settings (46). These included the usefulness of (1) establishing a network of clinicians within the health plan who will champion the program with their colleagues and move the initiative forward, (2) building relationships with community-based organizations in order to be in touch with the needs of the community, (3) participation of a multidisciplinary group in creating the initiative, and (4) provision of ongoing education to health care professionals during staff meetings, lunches, and other gatherings. Despite the progress that some health institutions or organizations have made, however, no scientific evaluation data exist that indicate specific policies or procedures institutions can adopt that are most effective at enhancing the quality of care women receive related to IPV. In the absence of well-defined outcome measures and goals for clinical care, institutions, like clinicians, will be hampered in their progress toward incorporating screening for violence against women into routine reproductive health care services.

CONCLUSION

Even as awareness of IPV as an important women's health issue is on the increase among health care providers, an essential element of the prevention paradigm remains missing. We know that the problem of violence is widespread, potentially affecting 1.5 million women over the age of 18 years each year (47), and we know that reproductive health care services offer an important opportunity to detect violence and to improve women's reproductive health. However, we have not yet discovered what measures can be instituted in health care settings that will make a constructive difference in the lives of women who are at risk of or experiencing IPV. As long as providers are uncertain that their efforts are making a positive difference in women's lives, their reluctance to screen for IPV will persist. Moreover, as long as reproductive health care services are not regarded by women as a place where they expect assistance that is helpful to them, they will not look to these services as a safe or useful place to disclose abuse.

Future clinical policies and procedures must be based on scientific evidence. Undoubtedly, one of the primary reasons this evidence does not yet exist is that the types of studies needed are complicated and expensive. The need to understand the potential effects of screening on women after they leave the clinical setting implies studies with follow-up designs that step outside the bounds of clinical service. The need to compare interventions in different clinical and community settings implies the use of comparable methods and measures across studies and may require multicenter study designs that can capture and compare more than a single clinical setting.

Whatever results lie in store as the science progresses, we can be sure that meeting the needs of women at risk of or experiencing IPV is certain to be more to be complicated than developing a set of universal screening guidelines that can be applied to all women in all places. We will be required to answer some difficult and perhaps controversial questions. First and foremost, can screening for violence effectively make measurable improvements in women's lives? If so, should some groups of women be screened more intensively than others? Does screening jeopardize the safety of some women or their children? As we continue to develop an appropriate role for reproductive health care services, we must consider the ethical responsibility providers and institutions have to offer constructive assistance to women who are identified through screening. Although the health care field has gone far in learning how to screen and how to increase screening rates in health care settings, meaningful progress will now depend on developing and evaluating interventions that can measure the effectiveness of screening and interventions. An essential key will be to evaluate

the impact of clinical screening and referral or intervention in improving women's safety and quality of life, and in reducing violence.

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